MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06383

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Juanita Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-resident infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Juanita Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bessye Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George W. Baker
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Dec. 13th 1888

8. AGE: Years: 58 | Months: 7 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Berlin Md (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: Joshua P. Johnson
13. Birthplace: Sussex Co. Delaware

MOTHER
14. Maiden name: Mary Jane Dennis
15. Birthplace: Pittsville Md.

16. Informant: Mr. George W. Baker
Address: Juanita Road Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. 7/30/47 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28th 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1933 19.. to July 28 1947 and that I last saw h.. alive on July 27 1947

Immediate cause of death	DURATION
Chronic myocarditis	14 yrs
Due to: H B P	14 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Brumm M. D.
M. D. or other
Address: Salisbury Date signed July 29 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

06384

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grace V. Banks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Col	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): a/pr 9-1934

8. AGE: Years	Months	Days	If less than one day
13	3	7	..... hrs. ..... min.

9. Birthplace: allen wicomico Md (Town, county, and state)
10. Usual occupation: school girl
11. Industry or business
FATHER 12. Name: Walter Banks
13. Birthplace: Fruitland Wicomico Md
MOTHER 14. Maiden name: Viola Polk
15. Birthplace: allen wicomico Md
16. Informant: Walter Banks
Address: Allen Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19 1947 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Allen Md
18. Funeral director: Charles H Ward
Address: Marion Md
19. 7/18, 1947 (Date rec'd by registrar) Harriet L Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1947 at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15th 1947, to July 16 1947
and that I last saw h.r alive on July 16th 1947

Immediate cause of death	DURATION
Chronic Valvular Disease	6 years
Due to: of Heart	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Eldon G. Mavis M. D. or other
Address: Princess Anne Date signed 7-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

06385 Reg. Dist. No. 336 #

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
12 Pine St
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Pine St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Blache M Bennett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry H. Bennett
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 21, 1859

8. AGE:

Years	Months	Days	If less than one day
88			hrs. min.

9. Birthplace Albany, N.Y. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER	12. Name	Jessie Bell
	13. Birthplace	Ireland
MOTHER	14. Maiden name	Unknown
	15. Birthplace	

16. Informant Mrs Kathleen Schiffer Address Delmar Del
17. Burial Date thereof 7-23-47 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or ~~crematory~~ Rural
Location Albany N.Y.
18. Funeral director W.S. Hyland Co Address Delmar Del
19. July 21st 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 8 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to July 21 1947
and that I last saw h alive on July 20 1947

Immediate cause of death	DURATION
Hypostatic pneumonia	4 days
Due to Fracture of neck of right femur	36 days
Due to	
Other conditions Arteriosclerotic heart dis.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of June 15 47
Where did injury occur? Delmar (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fall Injured at work? no

23. SIGNATURE K. V. Sohler M.D. M. D. or other
Address Delmar, Del. Date signed July 21 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06385

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years in Delmar
Hospital, institution, or street address where death occurred: U.S. Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants, give residence of mother)
State: Md. County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)
Street No.: 400 Elizabeth Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Theodore Berman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Berman
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): June 29 - 1896

8. AGE: Years 51 | Months 6 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Plumbing Supplies
11. Industry or business:

FATHER
12. Name: Morris Berman
13. Birthplace: Russia

MOTHER
14. Maiden name: Anna Colloff
15. Birthplace: Russia

16. Informant: Mr. Leon Berman
Address: 400 Elizabeth Ave. Delmar Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: July 5-47 (month) (day) (year)
Cemetery or crematory:
Location: Philadelphia Pa.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. (Date rec'd by registrar) 7/3 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3rd 1947 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3rd 1947 to July 3 1947 and that I last saw h[illegible] alive on July 3rd 1947

Immediate cause of death	DURATION
Myocardial infarct	
Due to: Coronary occlusion	
Due to: Arteriosclerosis of coronary arteries	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. V. Sohler M. D.
M. D. or other
Address: Delmar, Del. Date signed: 7-3-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 149a 06387

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:
County Wicomico
City or town ~~Eden~~ Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one day
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #2
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Mary Vertie Bivens

3.(b) Social Security Number No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	aa	married

6.(b) Name of husband or wife Glenmore Bivens
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
31	–	–	...hrs. ...min.

9. Birthplace Dames Quarter, Somerset Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Same

FATHER
12. Name Whalen White
13. Birthplace Dames Quarter, Somerset Co. Md.

MOTHER
14. Maiden name Don't know
15. Birthplace " "

16. Informant Glenmore Bivens
Address Eden, Md. Route #2.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 - 1947 (month) (day) (year)
Cemetery or crematory Dames Quarter
Location Dames Quarter

18. Funeral director James F. Stewart
Address 402 E. Church St, Salis. Md.

19. 7/10, 19 47 Harriet E. Johnson (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 47, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 19 47 to July 8 19 47
and that I last saw h er alive on July 8 19 47

Immediate cause of death	DURATION
Respiratory failure	
Due to Internal Hemorrhage	
Due to Ruptured uterus	
Other conditions Pregnancy at term	

(Include pregnancy within 3 months of death)
Major findings of operations Ruptured uterus.
Date of op. 7-8-47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE Robert R. Starr M. D. ~~or other~~
Address Salisbury Date signed 7-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. An exact statement of age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Kitts-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

06388

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Nelson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Brown Carroll Lee

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced
8.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 26, 1947
8. AGE: Years | Months | Days: 14 | If less than one day: 2 hrs. ..... min.
9. Birthplace Nelson Md. (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Rathel Lynn Earl
13. Birthplace Eldorado, Md.
MOTHER 14. Maiden name Brown Evelyn Frances
15. Birthplace Nelson Maryland
16. Informant
Address
17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 11, 1947 (month) (day) (year)
Cemetery or crematory Peninsula General Hospital
Location Salisbury Maryland
18. Funeral director P. F. & F.
Address Salis., Md.
19. June 11, 1947 (Date rec'd by registr) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 July 1947, at 7:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.. to 10 July 1947
and that I last saw h.. alive on 10 July 1947
Immediate cause of death PREMATURITY — DURATION 2 weeks
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operation
Date of op.
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. Kitts, M.D.
M. D. or other
Address Salisbury, Md. Date signed 11 July 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 170C

06389

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Somerset~~ Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 501 Laurel Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Russell Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19, 1908

8. AGE: Years	Months	Days	If less than one day
39	0	0	..... hrs. ..... min.

9. Birthplace: Accomac Co, Va. (Town, county, and state)

10. Usual occupation: Farm Labor

11. Industry or business

FATHER

12. Name: George Brown

13. Birthplace: Accomac County, Va.

MOTHER

14. Maiden name: Mary Taylor

15. Birthplace: Accomac County, Va.

16. Informant: Louise Mitchell

Address: 501 Laurel Ave. Pocomoke City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/1947 (month) (day) (year)

Cemetery or crematory: Wattsville Church Cem.

Location: Wattsville Va.

18. Funeral director: Howard A. Gill

Address: 401 Market St. Pocomoke City, Md.

19. 7/21 19 47 (Date rec'd by Registrar) H. T. Cassidy Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947, at 11A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19 ..... to ..... 19 ..... and ~~that I last saw him~~ alive on ..... 19 .....

Immediate cause of death	DURATION
Internal hemorrhage from Ruptured Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7/18/47

Where did injury occur? RT 13 (City or town) Somerset (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Auto accident Injured at work? No

23. SIGNATURE: Harry M. Lankford M.D.

M. D. or other

Address: Princess Anne Md. Date signed 7/19/47

Harry M. Lankford M.D. Deputy Medical Examiner for Somerset County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06390

159

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-26-47 to 7-30-47. 4 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1406 Rondale St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Girl Cramer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	✓

6.(b) Name of husband or wife:

6.(c) If alive, give age: 3 days years

7. Birth date of deceased (mo., day, yr.): 7-26-47

8. AGE:

Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace: Wic. Co. Md.
(Town, county, and state)

10. Usual occupation: infant

11. Industry or business

FATHER
12. Name: George Cramer
13. Birthplace: Walkersville, Md.

MOTHER
14. Maiden name: Madge Tyler
15. Birthplace: Charlo, Md.

16. Informant: George Cramer
Address: 1406 Rondale St, Baltimore, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 31, 1947 (month) (day) (year)

Cemetery or crematory: Peninsula General Hospital

Location: Salisbury Md

18. Funeral director: Peninsula General Hospital

Address: Salisbury Md.

19. 8/2 19 47 H. L. Kessler C.E. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-47 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-26-47 19 to 7-30-47 19 and that I last saw her alive on 7-30-47. 19

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stedman W. Smith M. D. or other

Address: Salisbury, Md. Date signed: 7-30-47

06391

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Diat. No. 933

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury R 3 D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Caroline M. Crisfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1860

8. AGE: Years	Months	Days	If less than one day
86	7	24	..... hrs. ..... min.

9. Birthplace: Princess Anne Md. (Town, county, and state)

10. Usual occupation: Retired School Teacher

11. Industry or business

FATHER 12. Name: John Woodland Crisfield

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Handy

15. Birthplace: Md.

16. Informant: Mr. Philip C. Dennis

Address: Ocean City Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 8/2/47 (month) (day) (year)

Cemetery or crematory: Church yard

Location: Princess Anne Md

18. Funeral director: Jesse A. Benton

Address: Berlin Md.

19. (Date rec'd by registrar) 8/5 1947 H. L. Harris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1947 to July 31 1947

and that I last saw h.. alive on July 30 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Hypertension, cerebral (Renal)	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Lynch M. D. or other

Address Salisbury Md. Date signed Aug 1 47

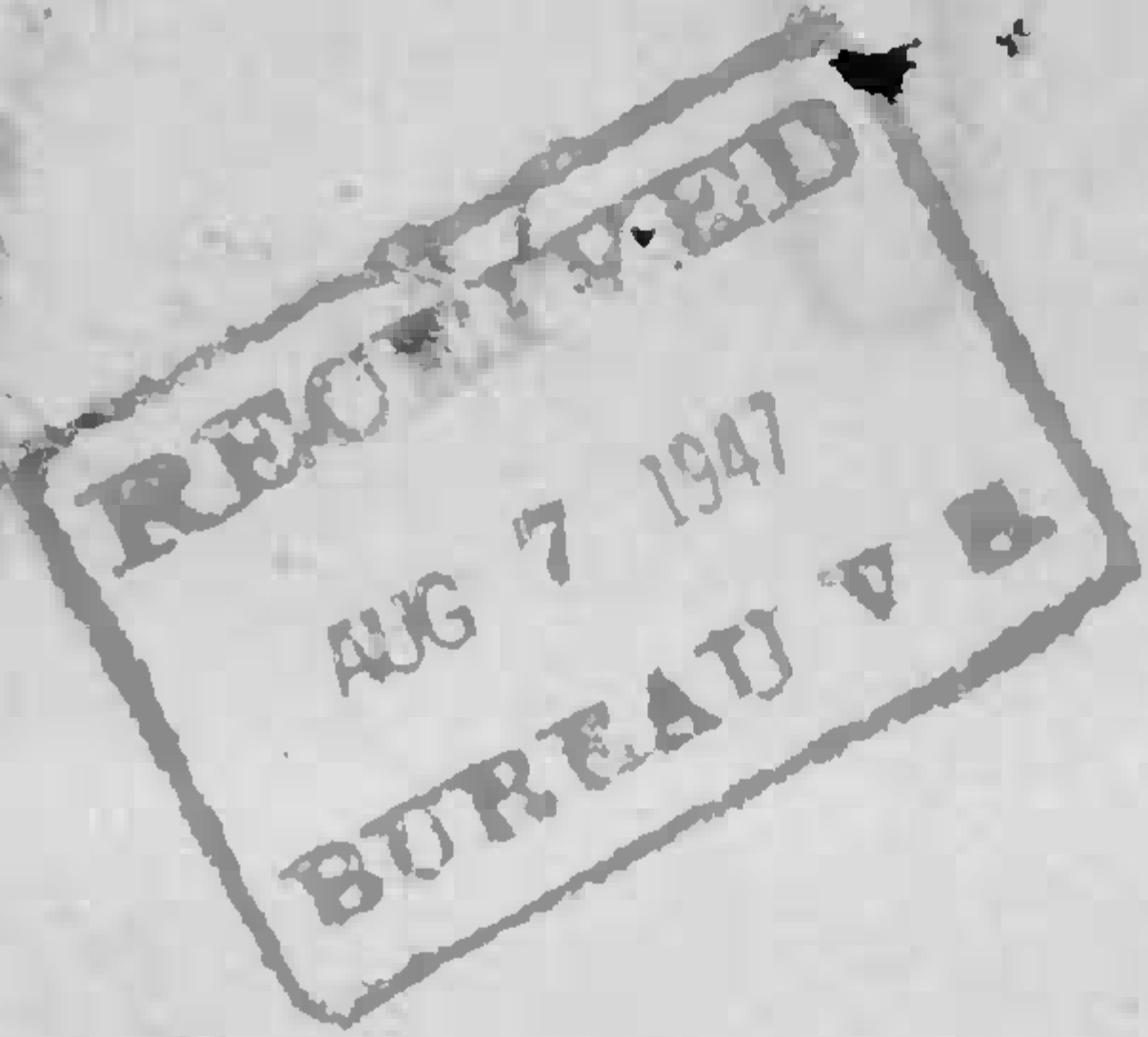
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

The Dr. did not send the attached certificate back to the undertaker in time for it to be mailed to me for a permit.

Sincerely
Harriet E. Johnson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AUG 7 1947
BUREAU

06392

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1256

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Disharoon, Mrs Lillie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer T. Disharoon

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	3	...hrs. ...min.

9. Birthplace: Richmond Co. Va. (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: Benjamin Smoot

13. Birthplace: Va

MOTHER — 14. Maiden name: Mary Jane Balderson

15. Birthplace: Va

16. Informant: Miss Esther Disharoon

Address: Quantico Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 / 47 (month) (day) (year)

Cemetery or crematory: Quantico Cemetery

Location: Quantico, Md.

18. Funeral director: Levin R. Wilson

Address: Princess Anne Md

19. 7/4 (Date rec'd by registrar) 19 47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 July 19 47 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 June 19 47 to 2 July 19 47 and that I last saw h.e alive on 2 July 19 47

Immediate cause of death	DURATION
Acute Hepatitis	5 days
Due to: Infection, Duodenal Ulcer	5 days
Due to:	
Other conditions: Enlarged Liver	years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Acute Hepatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: H. A. Brile M.D. M. D., or other

Address: 304 N Division St Date signed: 2 July 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Duplicate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06393

61

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: P. H. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 Anne St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Paul Ewell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie E. Ewell
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): March 19-1889

8. AGE: Years	Months	Days	If less than one day
58	3	29	hrs. min.

9. Birthplace: Westover, Maryland (town, county, and state)
10. Usual occupation: Electrician
11. Industry or business:

FATHER
12. Name: William Ewell
13. Birthplace: Somerset Co. Md.

MOTHER
14. Maiden name: Mary Dorsey
15. Birthplace: Westover Md.

16. Informant: Mrs Edison E. Ewell
Address: 309 Anne St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20-47 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury Maryland
18. Funeral director: Hollowa[illegible] & Co. Walter R. Gillmore
Address: Salisbury Maryland.
19. 7/20/47 (Date rec'd by registrar) H. L. Pollitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18th 1947 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 18 1947 and that I last saw him alive on July 17 1947

	DURATION
Immediate cause of death: Cerebral Embolus	5 days
Due to: Endocardial Mural Thrombi from Acute Coronary Occlusion	18 days
Due to:	
Other conditions: Diabetes Mellitus Hypertension (Include pregnancy within 3 months of death)	

Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: J. David Gillmore M.D.
M. D. or other
Address: 301 N. Division Salisbury Date signed: July 18, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

06394

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 516 Isabella St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Minnie L Bassett

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
female	a. a.	Married

6.(b) Name of husband or wife: Henry Bassett Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1878

8. AGE: Years	Months	Days	If less than one day
69 about			hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Household Keeping

11. Industry or business: Same as above

FATHER 12. Name: John Minder

FATHER 13. Birthplace: Salisbury Md

MOTHER 14. Maiden name: Olivia Handy

MOTHER 15. Birthplace: Salisbury Md

16. Informant: Mrs. Florence Henry

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1947 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury Md

18. Funeral director: Jesse A. Stewart

Address: Salisbury Md

19. 7/18 1947 (Date rec'd by registrar) Basil D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-16 1947, at 8:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-16- 1946, to 7-16 1947 and that I last saw h... alive on 7-16- 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	Over 1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

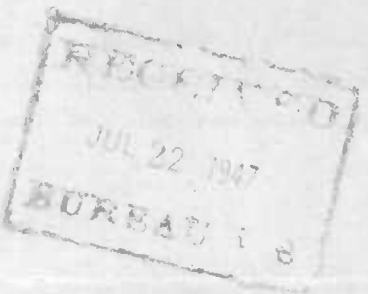
23. SIGNATURE: S A Purnell, M.D. or other

Address: 200 W. Main Salisbury Date signed 7-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06395

170c

CERTIFICATE OF DEATH

Reg. Diat. No. 733

1. PLACE OF DEATH:
County: Penn Hospital Salisbury
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 minutes
Hospital, Institution, or street address where death occurred:
Penn. Hospital
How long in hospital or institution? 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somerset
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Stanley L. Ford

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dela Ford
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1882

8. AGE: Years: 64 | Months: 10 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Magistrate

11. Industry or business

FATHER
12. Name: Jno. H. Ford
13. Birthplace: Md

MOTHER
14. Maiden name: Elizbeth Ford
15. Birthplace: Md

16. Informant: Dela Ford
Address: Princess Anne

17. (Burial, cremation, or removal. Which?) Date thereof: July 6 1947 (month) (day) (year)
Cemetery or crematory: St Andrews
Location: Princess Anne

18. Funeral director: P M Smith
Address: Princess Anne

19. 7/6 1947 (Date rec'd by registrar) H. Harrell Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1947 at 9.45P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Multiple Injuries	
Injuries of Body	
Due to Fatal	
Due to Auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7/4/47
Where did injury occur? Princess Anne (City or town) Somerset (County) Md (State)
Injured at home, farm, industry, public place (where?): Public Road
Means of injury: Hit by Auto Injured at work? No

23. SIGNATURE: Henry M. Cooper M.D.
M. D. or other
Address: Princess Anne Md Date signed: 7/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06396

CERTIFICATE OF DEATH

Reg. Dist. No. 337.

1. PLACE OF DEATH:

County Wicomico

City or town Tyaskin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred: Tyaskin

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Tyaskin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Isaac Albert Gates

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	col	married

6.(b) Name of husband or wife Annie L. Gates

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 20, 1849

8. AGE: Years	Months	Days	If less than one day
98	2	8	hrs. min.

9. Birthplace White Haven, Wicomico, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER — 12. Name Silers Gates

FATHER — 13. Birthplace White Haven, Md.

MOTHER — 14. Maiden name Unknown

MOTHER — 15. Birthplace "

16. Informant Annie L. Gates

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/47 (month) (day) (year)

Cemetery or crematory Head of Creek Cem.

Location Tyaskin, Md.

18. Funeral director C. G. Messick

Address Bivalve, Md

19. July 3, 1947 (Date rec'd by registrar) R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 21 April 1947 to 29 July 1947 and that I last saw h.. alive on 29 July 1947.

	DURATION
Immediate cause of death: Arteriosclerotic Cardio-vascular-renal disease	?
Due to: Arteriosclerosis.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

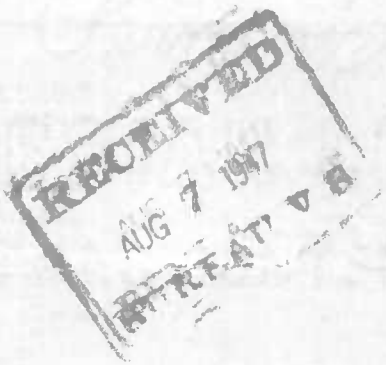
23. SIGNATURE Dr. Conrad H. Saunders M.D. M. D. or other

Address Dr. Saunders M.D. Date signed 29 July 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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AUG 7 1947

R. Stark

06397

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 84 years
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or Institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town ~~Fruitland~~ Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 N. Division St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Graham Mrs. Mary

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Joseph A. Graham
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 7, 1862

8. AGE: Years 74 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury, Wicomico Co., Md.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John D. Williams
13. Birthplace Wicomico Co., Md.

MOTHER
14. Maiden name Mary Ellen Jones
15. Birthplace Wicomico Co. Md.

16. Informant Miss Mary Gordon Toadvine
Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/21/47 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.
Address Salisbury, Maryland

19. 7/21/1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
Respiratory failure
Due to Shock
Due to Fracture of rt. hip - 3 days
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op.....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7-16-47
Where did injury occur? Salisbury, Wicomico, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) At Home
Means of injury Fell Injured at work?

23. SIGNATURE Robert R. Starr M. D.
Deputy medical examiner
Address Salisbury Date signed 7-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


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JUL 29 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93 e

06398

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred: Hammond Street,
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. Hammond Street (If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME George Alfred Greenslade

3.(b) Social Security Number .....

4. Sex Male MALE
5. Color or race White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Eva J. Greenslade
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct. 18- 1864
8. AGE: Years 82 Months 8 Days 14 If less than one day ..... hrs. ..... min.
9. Birthplace England (Town, county, and state)
10. Usual occupation Retired Civil Engineer
11. Industry or business Asst. Supt. Railroad in Cuba
12. FATHER Name No Record (Greenslade)
13. Birthplace England.
MOTHER 14. Maiden name No Record
15. Birthplace England.
16. Informant Miss Carolina Greenslade
Address Hammond St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19-47 (month) (day) (year)
Cemetery or crematory Wico. Mem. Park
Location Salisbury Maryland
18. Funeral director Holloway & Walter K. Holloway
Address Salisbury Maryland
19. 7/18 1947 Received by registrar Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946 to July 6 1947
and that I last saw him alive on 7-6-47
Immediate cause of death Congestive Heart Failure — Duration 8 mon.
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Lee L Lowry M. D. or other
Address Fruitland Md Date signed 7-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Kitts

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

06399

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 415 Naylor St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonresidents give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 415 Naylor St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Brenda Faye Haddock

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 21 - 1945
8. AGE: Years: 2 Months: 5 Days: 4 If less than one day: hrs. min.
9. Birthplace: Pr. Frederick Salisbury Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: C. Medford Haddock
13. Birthplace: R.D. Delmar Md.

MOTHER
14. Maiden name: Ruth Nancy Horseman
15. Birthplace: R.D. Delmar Del

16. Informant: Mr. C. Medford Haddock
Address: 415 Naylor St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27-47 (month) (day) (year)
Cemetery or crematory: M.P. Cem.
Location: Delmar Del
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md
19. 7/27 (Date rec'd by registrar) 19 47 Harriet L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25th 19 47 at 12 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 19 47 to 25 July 19 47 and that I last saw her alive on 23 July 19 47

Immediate cause of death	DURATION
Acute Lymphatic Leukemia	9 weeks
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Aid Kitts, M.D.
M. D. or other
Address: Salisbury, Md Date signed: 26 July 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. See that age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06400

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 419 E. Isabella, st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 419 E. Isabella, st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Raymond Garfield Hancock

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Hancock
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 1st 1881
8. AGE: Years: 66 Months: 0 Days: 21 If less than one day: hrs. min.
9. Birthplace: Stockton Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:

FATHER
12. Name: Wilmer J. Hancock
13. Birthplace: Worcester Co. Maryland

MOTHER
14. Maiden name: Martha Bonnyville
15. Birthplace: P.O. Poecomoke Maryland

16. Informant: M. Otho Hancock
Address: Johnson st. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24th 1947 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.
19. 7/22/47 (Date rec'd by registrar) Gabriel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd 1947 at 6:30 a.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 9 47 19 to July 22 19 47 and that I last saw him alive on July 22 19 47

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred A. Groves M.D. M. D. or other
Address: Salisbury, Md. Date signed 7/22/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06401

50

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 19 Days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? about 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Laura A Harmon

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A. A.	Married

6.(b) Name of husband or wife: Charles Harmon

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years: 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Prince Land Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER — 12. Name: John Hudson

FATHER — 13. Birthplace: Prince Land Md

MOTHER — 14. Maiden name: Sarah Parker

MOTHER — 15. Birthplace: Parsonsburg Md

16. Informant: Mrs Ethel M E Glutten

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22 1947 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Princess Anne Md

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. 7-22-1947 (Date rec'd by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-19 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 7-19 1947

and that I last saw h.. alive on 7-19 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to: Carcinoma Breast.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma breast

Date of op. 1940

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

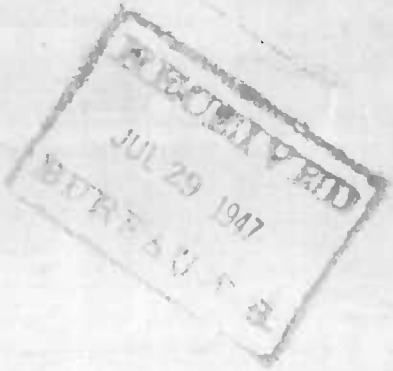
23. SIGNATURE: Chas A Tuohy M. D. or other

Address: Salisbury Md Date signed 7-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 29 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Purnell 932 06402

CERTIFICATE OF DEATH

Reg. Diat. No. 533

1. PLACE OF DEATH:

County Wicomico

City or town Rural Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo

Hospital, institution, or street address where death occurred: Baker St. Jersey Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) Jersey Road

2.(a) If veteran, name war

3.(a) FULL NAME Nathan Harmon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col	Widowed

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 15 1879

8. AGE: Years 68 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Good Hope Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business none

FATHER 12. Name James Harmon

FATHER 13. Birthplace Good Hope

MOTHER 14. Maiden name Millie Parker

MOTHER 15. Birthplace Md.

16. Informant Mrs Madelie Mutes

Address Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1947 (month) (day) (year)

Cemetery or crematory Parsons Cem

Location Salisbury Md

18. Funeral director Baker M. West

Address Salisbury Md.

19. 7/18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 16 1947 and that I last saw h.. alive on July 16 1947

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E Purnell, MD, M. D. or other

Address 900 W. Main Salisbury Date signed 7-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

06403

336

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:
308 East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 308 East
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Elijah William Hastings

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Phillie Hastings

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): May 8, 1874

8. AGE: Years: 73 Months: Days: If less than one day: hrs. min.

9. Birthplace: Delmar, Maryland
(Town, county, and state)

10. Usual occupation: Retired Car Inspector

11. Industry or business: Penn. Railroad Co.

FATHER
12. Name: Hezekiah Hastings
13. Birthplace: Delmar, Maryland

MOTHER
14. Maiden name: Mary E. Hastings
15. Birthplace: Delmar, Delaware

16. Informant: Mrs Phillie Hastings
Address: Delmar, Del.

17. Burial (Burial, cremation or removal. Which?) Date thereof: 7-22-47 (month) (day) (year)

Cemetery or crematory: First Methodist

Location: Delmar, Delaware

18. Funeral director: W. S. Mansel Co

Address: Delmar, Delaware

19. July 22, 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947 at 4.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1936 to July 19 1947

and that I last saw him alive on July 19 1947

Immediate cause of death	DURATION
Uremic coma	3 days
Due to Chronic Nephritis	1 yr
Due to Previous Trauma	11 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Ewell M. D. or other

Address: Delmar Del Date signed: July 24 1947

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06404

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 2/6/46

Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sana.

How long in hospital or institution? Since 2/6/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HASTINGS, Maude Estelle

3.(b) Social Security Number

220-10-9853

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Hastings

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 8, 1917

8. AGE: Years	Months	Days	If less than one day
30	2	10	hrs. min.

9. Birthplace: Fruitland, Maryland
(Town, county, and state)

10. Usual occupation: Ticket Agent

11. Industry or business

FATHER
12. Name: Edward Causey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mamie Schofield
15. Birthplace: Maryland

16. Informant: Patient on admission to Hosp.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/47 (Month) (day) (year)

Cemetery or crematory: St. John's Church

Location: Fruitland, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 7/19/47 (Date rec'd by registrar) H. Hazlett Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947, at 10:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to 7/18/47 1947

and that I last saw her alive on July 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis - Far Advanced	5 years
Due to	5 month
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury, Maryland Date signed 7/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore . 93d

CERTIFICATE OF DEATH

06405 K

Reg. Dist. No. 337

M

1. PLACE OF DEATH:
County Wicomico
City or town Jesterville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Jesterville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Heath

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Matilda Maley
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 28, 1856

8. AGE: Years	Months	Days	If less than one day
90	10	20	____ hrs. ____ min.

9. Birthplace: Jesterville, Wicomico, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: John T. Heath
13. Birthplace: Quantico, Md.
MOTHER 14. Maiden name: Susan White
15. Birthplace: Wetipquin, Md.
16. Informant: Minnie E. Day
Address: Jesterville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/47 (month) (day) (year)
Cemetery or crematory: Cemetery, Oak Grove
Location: Jesterville, Md.
18. Funeral director: C. S. Messick
Address: Bivalve, Md.
19. July 21 1947 (Date rec'd by registrar) R. Wolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947 at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1st 1947 to July 17th 1947
and that I last saw h. alive on July 17th 1947

Immediate cause of death	DURATION
Chronic Bronchitis	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

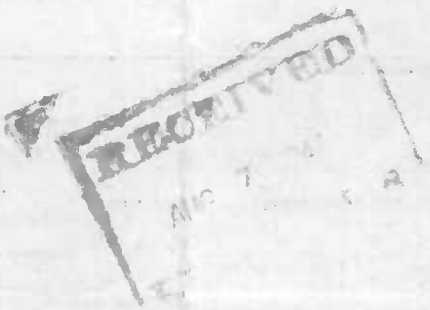
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Helen, Md. Date signed: July 20-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.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06406

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 7/7/47

Hospital, institution, or street address where death occurred: E. S. Tuberculosis Sanatorium

How long in hospital or institution? Since 7/7/47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Champ (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: HOPKINS, Omar Allen

3. (b) Social Security Number: 212-18-6972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace Hopkins

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): June 28, 1893

8. AGE: Years	Months	Days	If less than one day
54	0	18	...hrs. ...min.

9. Birthplace: Somerset County, Maryland (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER — 12. Name: George Hopkins

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary K. Ford

MOTHER — 15. Birthplace: Maryland

16. Informant: self (Patient at time of Admission)

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1947 (month) (day) (year)

Cemetery or crematory: Oriole

Location: Oriole, Md.

18. Funeral director: Dale Washiell

Address: Princess Anne, Md.

19. 7/16/47 (Date rec'd by registrar) Harriet J. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1947, at 7:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947, to July 16 1947 and that I last saw him alive on July 15 1947

Immediate cause of death: Acute Cardiac failure — DURATION: 13 months & Bc.

Due to: Heart Chain.

Due to: Pulmonary Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: S. T. Hooper M. D. or other

Address: Salisbury, Maryland Date signed 7/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06407

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

1. PLACE OF DEATH:

County: Wicomico

City or town: Hebron

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Hebron - Route 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary R. Horsman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

8.(b) Name of husband or wife: James Horsman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	16	hrs. min.

9. Birthplace: White Haven, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: George Robertson

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Don't Know

MOTHER — 15. Birthplace: " "

16. Informant: Lloyd Burkes

Address: Hebron, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/8/47 (month) (day) (year)

Cemetery or crematory: Bivalve Church Cem.

Location: Bivalve, Md.

18. Funeral director: C. G. Messick

Address: Bivalve, Md.

19. 7/8/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1947, to July 6th 1947 and that I last saw her alive on July 6th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Hebron - Md. Date signed: July 7-47

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

T

Dr Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

06408

CERTIFICATE OF DEATH

Reg. Diat. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 27 hrs Approx

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury R.F.D. # 4

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jones, Mr. John W.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6.(b) Name of husband or wife Mrs. Lillian Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 6 - 1889

8. AGE:

Years	Months	Days	If less than one day
58	5	25	..... hrs. ..... min.

9. Birthplace R.D. # 4. Salisbury Md.
(Town, county, and state)

10. Usual occupation Supervisor of State Highways

11. Industry or business Eastern Shore of Md

FATHER
12. Name John Purnell Jones
13. Birthplace R.D. # 4. Salisbury Md.

MOTHER
14. Maiden name Lizzie H. Jones
15. Birthplace R.D. # 4. Salisbury Md

16. Informant Mrs. Lillian W. Jones

Address R.D. # 4. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3-47 (month) (day) (year)

Cemetery or crematory Parsonsburg, Wicom.

Location Parsonsburg, Md.

18. Funeral director Tilghman & Walter R. Tilghman

Address Salisbury Md.

19. 7/3, 1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 1, 1947, at 1 15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw him alive on 6-30 19.. I viewed corpse

Immediate cause of death	DURATION
Ruptured Bladder	24 hrs
Hemorrhage Pelvis	24 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ao abdo

Date of op. 7/30/47

Autopsy results Ruptured bladder. peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/30/47

Where did injury occur? No. Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) public highway

Means of injury Truck ran over him Injured at work? yes

23. SIGNATURE J.O. Rademacher M.D. deputy med examiner

Address Salisbury Md M. D. or other

Date signed 7/2/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06409

CERTIFICATE OF DEATH

Reg. Dist. No. 333

STARR 195 e

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Enroute to Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Springhill Road

(If outside city or town limits, write RURAL and give nearest town)

Street No. Salisbury, Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jones, Mr. Milton Henry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Doris Koerber Jones

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) January 28, 1915

8. AGE:

Years	Months	Days	If less than one day
32	5	28	..... hrs. ..... min.

9. Birthplace Chance - Somerset - Md (Town, county, and state)

10. Usual occupation Auto dealer

11. Industry or business Auto

FATHER

12. Name William D. Jones

13. Birthplace Chance, Md

MOTHER

14. Maiden name Margaret Mandlhal

15. Birthplace Jamestownville, Md

16. Informant Mrs. Doris Jones

Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30-1947 (month) (day) (year)

Cemetery or crematory Chance Cemetery

Location Rural, Chance, Md

18. Funeral director H Harvey Bradshaw

Address Eastside, Md

19. 7/27, 19 47 Harold E. Johnson Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Subarachnoid hemorrhage	
Due to Contusion of head	
Due to	
Other conditions Acute alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Subarachnoid hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 26, 1947

Where did injury occur? Salisbury, Wicomico, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) County Jail

Means of injury External Contusion Injured at work? No

23. SIGNATURE Robert R. Starr, M.D. Deputy medical examiner (Coroner or other)

Address Salisbury Date signed 7-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06410

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? Since 11/2/46

Hospital, Institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium

How long in hospital or institution? Since 11/2/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

JOPP, Frances Culp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	12	hrs. min.

9. Birthplace: Harrisburg, Pennsylvania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: William Henry Jopp
13. Birthplace: Marietta, Pennsylvania

MOTHER
14. Maiden name: Mary Ellen Taylor
15. Birthplace: Mechanicsburg, Pennaylvania

16. Informant: self
Address

17. (Burial, cremation, or removal) Which?: Burial Date thereof: (month) (day) (year)
Cemetery or crematory: Denton Cemetery
Location: Denton md

18. Funeral director: Jr Virgil Mason
Address: Denton, Md

19. (Date rec'd by registrar) 7/2, 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2, 1947, at 4:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947, to July 2, 1947
and that I last saw her alive on July 1, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis (Far Advanced)	12 months
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: S W Shrader MD
M. D. or other

Address: Salisbury, Maryland Date signed: 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

06411

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos.
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Alba E. Kinney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 3 1869

8. AGE: Years: 87 | Months: 11 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Laurel Del. (Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business:

FATHER
12. Name: Wm. L. Moore
13. Birthplace: Laurel Del

MOTHER
14. Maiden name: Margaret Wheatley
15. Birthplace: Laurel Del

16. Informant: Paul Kinney
Address: Snow Hill Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: 7 29 47 (month) (day) (year)
Cemetery or crematory: Odd Fellow Cemetery
Location: Laurel Del
18. Funeral director: Reginald L Cooper
Address: Laurel Del

19. (Date rec'd by registrar) 7/29/47 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured hip	1 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of June 25 47
Where did injury occur: Snow Hill Worcester Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Fell on floor injured at work? No

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed: 7-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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06412

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.S. Bryant,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 East Locust St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Lee Long.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lovina J. Long.
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 19 1907

8. AGE:

Years	Months	Days	If less than one day
40	1	3	hrs. min.

9. Birthplace: Pocomoke Maryland
(Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: City of Salisbury Md

FATHER
12. Name: George J. Long
13. Birthplace: Pocomoke Md.

MOTHER
14. Maiden name: Lula Megan
15. Birthplace: Pocomoke Md.

16. Informant: Mrs. Lovina J. Long
Address: 313. East Locust St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26-47 (month) (day) (year)
Cemetery or crematory: Bryant Plan.
Location: Salisbury Md
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 7/26/47 (Date rec'd by registrar) Carrie L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22nd 1947, at 5.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Contusion and Drowning	
Due to: Suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy, results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 7/22/47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?): House.
Means of injury: Truck contusion Injured at work? No

23. SIGNATURE: Elmer J. Fooks M.D.
Deputy Medical Examiner M. D. or other
Address: Salisbury Md. Date signed 7/22/47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

06413

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: 306 D. Division

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 D. Division

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nellie Majors

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Mister Majors

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1888

8. AGE: Years	Months	Days	If less than one day
58	10	1	hrs. min.

9. Birthplace: Westpoint Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home.

FATHER — 12. Name: John Porter

FATHER — 13. Birthplace: Westpoint Md.

MOTHER — 14. Maiden name: Rebecca Smith

MOTHER — 15. Birthplace: Westpoint Md.

16. Informant: Mr. Mister Majors

Address: 306 D. Division St Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1947 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md.

18. Funeral director: Holloway & Costen Funeral Home

Address: 520 E. Church St. Salisbury Md.

19. 7/8/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1947, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947, to July 6 1947 and that I last saw h[illegible] alive on July 6 1947

Immediate cause of death	DURATION
Carcinoma of Rectum	Symptoms 2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work?

23. SIGNATURE David J. Gilmore M.D. M. D. or other

Address 306 D. Division Salisbury Date signed July 7, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Dr. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

06414

Reg. Diat. No. 399

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Temple Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Eden

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mc. Kinstry

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: July | Days: 16 | If less than one day: 18 hrs. ..... min.

9. Birthplace: Salisbury (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Mc. Kinstry Sam Jr.

FATHER 13. Birthplace: Homestead, Florida

MOTHER 14. Maiden name: Cross Vivian Barbara

MOTHER 15. Birthplace: Okeechobee, Florida

16. Informant

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)

Cemetery or crematory: V. F. W.

Location: Salisbury md.

18. Funeral director: Peninsula General Hospital

Address: Salisbury md.

19. July 19, 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1947, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16th 1947 to July 17th 1947 and that I last saw him alive on July 17th 1947

Immediate cause of death	DURATION
Prematurity - 7 mos.	
Due to: Premature Labor.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Prematurity.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Stedman W. Smith M.D. C.M.

M. D. or other

Address: Salisbury Md. Date signed 7-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06415

170c

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~7~~ ~~days~~ 54 days

Hospital, Institution, or street address where death occurred: Peninsula Regional Hospital

How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mills, Mrs Susie L.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Mills

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 9, 1881

8. AGE:

Years	Months	Days	If less than one day
76	0	22	hrs. min.

9. Birthplace: Quantico, Wicomico Co., Maryland (Town, county, and state)

At Home

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Theadore Disharoon

FATHER 13. Birthplace: Wicomico Co., Maryland

MOTHER 14. Maiden name: Elizabeth B. Larmore

MOTHER 15. Birthplace: Wicomico Co., Maryland

16. Informant: Otis V. Tayler

Address: 101 W. Calloway St; Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/3/47 (month) (day) (year)

Cemetery or crematory: Wicomico Memorial Park

Location: Salisbury, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 7/3 19 47 (Date rec'd by registrar) Earnest E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 47 at 5 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Medical~~ 19 ~~not attended~~ 19

and that I last saw him alive on ~~Medical Exam~~ well patient 19

Immediate cause of death	DURATION
Fractured Rt Femur	4 days
Rt Humerus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6-26-47

Where did injury occur? Delmar (City or town) Sussex (County) Del (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury Car skidded Injured at work? No

23. SIGNATURE: ~~Medical Examiner~~ Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed 7/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06416

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico Co.

City or town: Pine Bluff San. Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since June 6, 1947

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 4 wks + 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Caroline

City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. Nr. Vaughn Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Edward Minner

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec. 16; 1890

8. AGE: Years	Months	Days	If less than one day
56	6	18	...hrs. ...min.

9. Birthplace: Queen Anne Co. Md.
(Town, county, and state)

10. Usual occupation: none - blind

11. Industry or business: —

FATHER
12. Name: Nathan Minner
13. Birthplace: Delaware

MOTHER
14. Maiden name: Susan Coley
15. Birthplace: Delaware

16. Informant: by Self when admitted as pt.
Address: —

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 5 1947 (month) (day) (year)

Cemetery or crematory: Greensboro

Location: Greensboro Md.

18. Funeral director: R. B. Rawlings

Address: Greensboro, Md.

19. 7/6 (Date rec'd by registrar) 1947 Carrie L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947, at 7 15 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1947 to July 5 1947 and that I last saw h... alive on July 5 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: S. C. Brundage M D
M. D. or other

Address: Salisbury Date signed 7/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06417

CERTIFICATE OF DEATH

Reg. Dist. No. 993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:
P. G. Hospital.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town White Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katie Elizabeth Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Carlton H. Moore

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1871

8. AGE: Years	Months	Days	If less than one day
75	6	10	hrs. min.

9. Birthplace Lisbon, Howard, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph T. Richards
13. Birthplace Dubendorea, Md.

MOTHER
14. Maiden name Hannah Anne Melsey
15. Birthplace Baltimore, Md.

16. Informant Leona Kirwin

Address Tyaskin, Md.

17. Burial Date thereof 7/6/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Tyaskin M. E. Cem.

18. Funeral director C. E. Messick

Address Bivalve, Md.

19. 7/6 19 47 H. T. Harris Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 47, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 June 19 47, to 3 July 19 47.

and that I last saw h... alive on 3 July 19 47.

	DURATION
Immediate cause of death Cerebral Accident	10 days
Due to Hypertensive Sclerosis accelerative Cardio vascular Renal Disease	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Roland H. Saunders M. D.
M. D. or other

Address Hartsville Md. Date signed 5 July 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06418

CERTIFICATE OF DEATH

Reg. Dist. No. # 336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D # 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edith Mae Oliphant Dennis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Caldwell J. Dennis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 18. 1872

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Wicomico County, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name John B. Oliphant

FATHER 13. Birthplace Wicomico County, Md.

MOTHER 14. Maiden name Elizabeth Bounds

MOTHER 15. Birthplace Wicomico County, Md.

16. Informant Mrs. Walter Alexander

Address Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-8-47 (month) (day) (year)

Cemetery or crematory Smith Hill

Location Delmar, Del R F D

18. Funeral director W. S. Mansel Co.

Address Delmar Delaware

19. July 7th 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1947 to July 6 1947 and that I last saw h.er alive on July 6 1947.

	OURATION
Immediate cause of death Acute dilatation of heart	2 hrs
Due to Chronic Hypertension cardio Vascular Disease	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Lynch M. D. or other

Address Delmar Date signed July 7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Fisher
mw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170a

06419

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 15 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Laurel Route #2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Morris, Mr. Welton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Essie W. Morris

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) April 14-1913

8. AGE: Years 34 Months 3 Days 13 If less than one day hrs. min.

9. Birthplace Princess Anne Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Ellis Morris

13. Birthplace Portsville Delaware

MOTHER 14. Maiden name Effie Timmons

15. Birthplace Berlin Md.

16. Informant Mrs. Julia I. Cordrey

Address R.D. #2 Laurel Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31-47 (month) (day) (year)

Cemetery or crematory Bethel Methodist Church

Location Bethelton Maryland

18. Funeral director Hitchens & Walter R. Holland

Address Salisbury Maryland

19. 7/31/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1947 at 7.54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] to [illegible] and that I last saw him alive on [illegible]

Immediate cause of death	DURATION
Compound Fracture of Skull	[illegible]
Due to Automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/26/47

Where did injury occur? Pittsville Wicomico Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Struck by truck Injured at work? No

23. SIGNATURE [illegible] M. D. or other

Address Salisbury Md. Date signed 7-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06420

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 & 6 weeks
Hospital, institution, or street address where death occurred: 105, Cherry St (Lemmon Nursing Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cornelia May Frances Mumford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife: Virgil Mumford
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 29-1899

8. AGE: Years 52 | Months 10 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Nanjo Md
(Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business: at Home

FATHER
12. Name: John Parsley
13. Birthplace: Nanjo Md

MOTHER
14. Maiden name: Sallie May Dennis
15. Birthplace: P.O. Pauls Valley, Md

16. Informant: Mr. Herman M. Mumford
Address: RD #3. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4-47 (month) (day) (year)
Cemetery or crematory: Bethel Cem.
Location: Hebron Md

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md

19. 7/3/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 nd 1947 at 8:30 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to July 2 1947

and that I last saw h[illegible] alive on July 2 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 days

Due to: Arteriosclerosis — ?

Due to: Chronic Nephritis — ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John H. Heaman M.D.
M. D. or other

Address: 138 Lander Ave Salisbury Date signed: July 2, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Starr

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06421

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 120. Wilkins st.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 120. Wilkins street (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Robert Belmont Murrell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Minnie Lee Murrell

6.(c) If alive, give age ..... Dead ..... years

7. Birth date of deceased (mo., day, yr.) March 17-1874

8. AGE: Years 73 | Months 4 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace St. Louis Mo. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business .....

FATHER — 12. Name No Record

13. Birthplace .....

MOTHER — 14. Maiden name No. Record.

15. Birthplace .....

16. Informant Mrs. Elsie Davis

Address 120. Wilkins st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27-47 (month) (day) (year)

Cemetery or crematory Wi Co. Mem. Park

Location Salisbury Md

18. Funeral director Holloway & Walter R. Holloway

Address Salisbury Md.

19. 7/27/47 (Date rec'd by registrar) Harriet L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 47 at 5.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 25 1947 and that I last saw him alive on July 25 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to Coronary thrombosis	
Due to Hypertension & Cerebral embolism	3 wks.
Other conditions Uremia (terminal)	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Manner of injury ..... Injured at work?

23. SIGNATURE Robert R. Starr M. D.

Address Salisbury Date signed 7-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06422

61

CD

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Jewel

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: Anna Belle Nelson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. D. Nelson

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1876

8. AGE: Years: 70 | Months: 6 | Days: 24 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Crisfield, Maryland (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Home

FATHER

12. Name: Charles Laird

13. Birthplace: Crisfield, Maryland

MOTHER

14. Maiden name: Ellen Tyler

15. Birthplace: Crisfield, Maryland

16. Informant: William D. Nelson

Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11-1947 (month) (day) (year)

Cemetery or Crematory: Mt. Olive Methodist

Location: Delmar, Delaware

18. Funeral director: H. S. Insell Co

Address: Delmar, Delaware

19. 7/11, 19 47 (Date rec'd by registrar) Harriet S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947, at 7.15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1946 to July 9 1947

and that I last saw h... alive on July 8 1947

Immediate cause of death	DURATION
Uremia	3 days
Due to: Chronic glomerulo-nephritis	?
Due to: Anuria acquired.	?
Other conditions: Diabetes mellitus	?
Myocardial heart disease	?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: J. V. Sohler M.D. (M. D. or other)

Address: Delmar, Del. Date signed: 7-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06423

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5-1 L

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH: Wicomico Co.
County
City or town Maedela
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: RD #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Maedela
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard H. Nichols

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Violet M. Nichols
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Oct. 29th 1879

8. AGE: Years	Months	Days	If less than one day
72	8	24	hrs. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name unknown
FATHER 13. Birthplace Canada
MOTHER 14. Maiden name Willson
MOTHER 15. Birthplace Canada
16. Informant Mrs. Violet M. Nichols
Address RD #2 Maedela, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26-47 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury, Maryland
18. Funeral director Holloway & Walter R. Hollis
Address Salisbury Maryland
19. 7/26/47 (Date rec'd by registrar) W.M.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23rd 1947 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1947 to July 22nd 1947 and that I last saw h.. alive on July 22nd 1947

Immediate cause of death	DURATION
Carcinoma of Prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other
Address Nelson - Md. Date signed July 24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06424

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

CD

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

P. G. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna County Lehister

City or town Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No ✓

3.(a) FULL NAME Parsons Mrs. Alice M.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Ernest W. Parsons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5 — 1876

8. AGE: Years 71 | Months 3 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Berlin, Worcester Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Asa Davis

13. Birthplace Maryland

MOTHER 14. Maiden name Mr. Bloom

15. Birthplace "

16. Informant Mrs Nellie P. Lambson

Address Berwyn, Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 1/47 (month) (day) (year)

Cemetery or crematory Bates Methodist

Location Snow Hill, Md

18. Funeral director Elmer A. Dennis

Address Snow Hill, Md

19. 7/31 1947 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 9:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1947, to July 29 1947 and that I last saw her alive on July 29 1947

Immediate cause of death	DURATION
Acute Coronary artery occlusion	12 hours
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Hypertension	Symptoms 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David J. Gilmore M. D. M. D. or other

Address 301 N. Division Salisbury Md. Date signed July 29, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Manual

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55e

06425

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 512 E. South Division
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Parsons Mr. William Virgil

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Ida Ellen Parsons
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) June 6 1871

8. AGE: Years 76 Months 1 Days 24 If less than one day hrs. min

9. Birthplace R.D. # Salisbury Md (Town, county, and state)
10. Usual occupation Retired Farmer + Lumberman
11. Industry or business

FATHER
12. Name Joshua J. Parsons
13. Birthplace R.D. Salisbury Md

MOTHER
14. Maiden name Mary E. Buckingham
15. Birthplace Pittsville Md

16. Informant Mrs. Hollie E. Pryor
Address 512 S. Division St. Salisbury Md

17. Buried Date thereof Aug 1st 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hammond Cem.
Location R.D. Salisbury Maryland

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland

19. 8/1/47 Harriet D. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1947 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to 7/30 1947 and that I last saw h[illegible] alive on 7/30/47 1947

Immediate cause of death Generalized Metastatic Sarcoma — DURATION
Due to Primary site: Rt. Chest Wall. (8/27/47 D.S.)
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results?
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred R. Adams M.D.
M. D. or other
Address Salisbury Md Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

06426

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6
Hospital, institution, or street address where death occurred: U.S. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-resident infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 913 Riverside Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: John Henry Peacock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Doris M. Peacock
6.(c) If alive, give age: 24 years
7. Birth date of deceased (mo., day, yr.): Nov. 19-1920

8. AGE: Years: 26 | Months: 8 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Somerset Co. Md.
(Town, county, and state)
10. Usual occupation: Regular Army
11. Industry or business: Clerk Body Works

FATHER
12. Name: John Henry Peacock
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Alice E. Powell
15. Birthplace: Dentons Md.

16. Informant: Wife. Doris M. Peacock
Address: 913 Riverside Drive Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 1-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 8/1 1947 (Date rec'd by registrar) Harriet L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 30 1947 and that I last saw h[illegible] alive on July 31 1947

Immediate cause of death	DURATION
Septicaemia	Weeks
Due to Infected Ear.	Weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

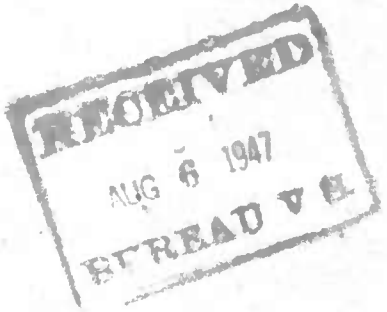
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of 9/1/47
Where did injury occur? Salisbury (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?) Wicomico County
Means of injury: Burned Injured at work? Yes

23. SIGNATURE: J. M. Mack M. D. or other
Address: Salisbury Date signed: 8/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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AUG 6 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Long 46 f 06427

Reg. Dist. No. 733

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Phillips, Mr. John E.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or wife~~ daughter Battle, Mrs. Fred

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1877

8. AGE: Years 69 | Months 11 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Columbia Sussex Del.
(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business

FATHER 12. Name Joseph Phillips

13. Birthplace Del

MOTHER 14. Maiden name Victoria Cooper

15. Birthplace Del.

16. Informant Joseph E. Phillips

Address Sharptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-5-1947 (month) (day) (year)

Cemetery or crematory Firemans

Location Sharptown

18. Funeral director Trader Bros

Address Sharptown

19. 7/4 1947 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-47 at 10 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1947 to July 3 1947 and that I last saw h.i.m. alive on July 3 1947

Immediate cause of death	DURATION
Primary Carcinoma of Liver	6-12 mon
Due to	
Due to	
Other conditions o	

(Include pregnancy within 3 months of death)

Major findings of operations Primary Carcinoma of Liver Date of op. 27 June 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. A. Beale M. D. or other

Address 5047 Emerson St Date signed 7-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Trader

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06428

Reg. Dist. No. 265

1. PLACE OF DEATH:
County: Worcester
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Westover
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Christine Pauline Pittman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 7, 1946

8. AGE:

Years	Months	Days	If less than one day
#	9	21	hrs. min.

9. Birthplace: Somerset County, Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: John Edward Mills
13. Birthplace: Pocomoke City, Md

MOTHER
14. Maiden name: Orer Lee Pittman
15. Birthplace: North Carolina

16. Informant: Orer Lee Pittman
Address: Pocomoke City, Md. Rt. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1947 (month) (day) (year)
Cemetery or crematory: Christ M. E. Cemetery
Location: Somerset County, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Crisfield, Md.

19. Aug. 1 1947 (Date rec'd by registrar) Janice E. Lynes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947, to July 28, 1947 and that I last saw h[illegible] alive on July 28, 1947

	DURATION
Immediate cause of death: Rickettsial Infection	
Due to: Rocky Mt. Spotted Fever (8/27/47 ds.)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles W. Trader M.D. M. D. or other
Address: Salisbury, Md. Date signed: 7-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Lilly Pittman

Over Lee Pittman
take picture

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06429

Reg. Diat. No. 335

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
San Domingo

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Frank M. Smiley

3. (b) Social Security Number: 220-09-1113

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Eloise H. Smiley

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): December 15, 1900

8. AGE: Years	Months	Days	If less than one day
46	5	1	...hrs. ...min.

9. Birthplace: Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business: Farm and Mill

FATHER
12. Name: Harmon Smiley
13. Birthplace: Wicomico County, Maryland

MOTHER
14. Maiden name: Eliza Watts
15. Birthplace: Wicomico County, Maryland

16. Informant: Mrs. Eloise H. Smiley
Address: Mardela Springs, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)

Cemetery or crematory: San Domingo Cemetery

Location: Near Sharptown, Maryland

18. Funeral director: J. K. Frampton & Son

Address: Federalsburg, Maryland

19. Jul. 16 1947 (Date rec'd by registrar) Walter R. Mumm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1947 at 1:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1947 to July 14 1947 and that I last saw h...alive on July 13 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 Months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other

Address: Sharptown Md Date signed: 7/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 36 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Kingston

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Stalvis, Maggie — Maggie Stalvis

3.(b) Social Security Number: 220-26-0985

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Robert Stalvis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown - about 1905

8. AGE: Years	Months	Days	If less than one day
Approx 42	?	?	..... hrs. ..... min.

9. Birthplace: Eastville-Northampton-Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: James Teagle

FATHER — 13. Birthplace: Pocomoke, Md.

MOTHER — 14. Maiden name: Adelaide Collins

MOTHER — 15. Birthplace: Eastville, Va.

16. Informant: Robert Stalvis

Address: Kingston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1947 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: RFD, Crisfield, Md.

18. Funeral director: H. Harvey Bradshaw

Address: Crisfield, Md.

19. 7/21, 1947 (Date rec'd by registrar) Harriet E. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18th, 1947, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1947, to June 22, 1947 and that I last saw her alive on June 22, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hours.
Due to: Malignant Hypertension	unknown
Due to:	
Other conditions: Hypertensive Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles W. Trader, M.D. (M. D. or other)

Address: Salisbury, Md. Date signed 7-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

0643 336

CERTIFICATE OF DEATH

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 304 Elizabeth, street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Elizabeth Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Elizabeth Sturgis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Thomas A. Sturgis
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March 22nd 1883

8. AGE: Years: 64 | Months: 4 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Delmar Maryland (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: John Wesley Williams
13. Birthplace: Delmar Delaware

MOTHER
14. Maiden name: Lavenia
15. Birthplace: Delaware

16. Informant: Mr. William Sturgis
Address: Delmar Road Salisbury Md

17. Burial, cremation, or removal. Which? Burial Date thereof: July 25-47 (month) (day) (year)
Cemetery or crematory: M.P. Cem.
Location: Delmar Delaware

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. July 23 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23rd 1947 at 2.40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to July 23 1947 and that I last saw h.r. alive on July 23 1947

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to Hypertensive Cardio Vascular Disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. H. Gunby M. D. or other
Address: Delmar Md. Date signed: July 23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06432

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH: Wicomico

County

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred: 415 Dock St. (Wright Nursing Home)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For N. born infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Dock St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Emily Toadvine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Geo. W. Toadvine

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April 26-1870

8. AGE: Years 77 | Months 2 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Shad Point Md. (town, county, and state)

10. Usual occupation: Retired

11. Industry or business: At Home

FATHER — 12. Name: Peter Cox

FATHER — 13. Birthplace: Wic. Co. Md.

MOTHER — 14. Maiden name: M. Pecas

MOTHER — 15. Birthplace:

16. Informant: Mrs. Seneca A. Young

Address: 501 Forstard St Wilmington Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16-47 (month) (day) (year)

Cemetery or crematory: Parsons Mem

Location: Salisbury, Maryland

18. Funeral director: Hollenger & Walter R. Fillmore

Address: Salisbury Md.

19. 7/15/47 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1947 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1947 to July 14 1947 and that I last saw h.r alive on July 14, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hrs.
Due to: Hypertension	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Toadvine M.D. M. D. or other

Address: Salisbury, Md. Date signed 7/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Briele

MARYLAND STATE DEPARTMENT OF HEALTH

06433

2411 N. Charles St., Baltimore

1700

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worchester
City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Truitt, Mrs. Flora
3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mr. John Truitt
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): July 22, 1904
8. AGE: Years 43 Months 0 Days 7 If less than one day ... hrs. ... min.
9. Birthplace: Berlin, Md. R.F.D. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James Davis
13. Birthplace: Md.
MOTHER 14. Maiden name: Cornelia Mitchell
15. Birthplace: Md.
16. Informant: Mrs. Bessie King
Address: Berlin, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/31/47 (month) (day) (year)
Cemetery or crematory: Truitt Fam.
Location: Md. Powellville R.F.D.
18. Funeral director: Irving A. Burbage
Address: Berlin, Md.
Per: Harriet E. Johnson
19. 7/30, 1947 (Date rec'd by registrar) Harriet E. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29th, 1947, at 4:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 July, 1947, to 29 July, 1947, and that I last saw her alive on 29 July, 1947.

Immediate cause of death	DURATION
Shock & retroperitoneal hemorrhage,	
Due to: Fracture lower 3 ribs & lumbar transverse processes bilateral,	12 hrs
Due to: & pubis left & lumbo sacral joints (lumbo sacral)	
Other conditions: (Senile) diabetes mellitus	

(Include pregnancy within 3 months of death)
Major findings of operations. Date of op.
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Acc. Date of: 7-28-47
Where did injury occur? St. Martin's, Worc. Co. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public
Means of injury: Automobile Injured at work?
23. SIGNATURE: H. A. Briele M. D. or other
Address: 307 N Division St Date signed: 7.29.47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06434

128

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Turner Mr. Arthur

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Stella Peck
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Oct. 23 1888

8. AGE: Years: 58 Months: 8 Days: 23 If less than one day: hrs. min.

9. Birthplace: Marion, N.Y. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Elias Turner
13. Birthplace: Newark, N.Y.

MOTHER
14. Maiden name: Roella Townsworth
15. Birthplace: N.Y.

16. Informant: Mrs. Lillian Boerman
Address: R.D. #1. Salisbury, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) July (day) 19 (year) 1947
Cemetery or crematory: Marion Cem.
Location: Marion, N.Y.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury, Maryland.

19. (Date rec'd by Registrar) 7/16/1947 Registrar: Harriet L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to July 16 1947 and that I last saw h. alive on 7-16-47 1947

Immediate cause of death	DURATION
Congestive Heart Failure	6 mon
Due to	
Due to	
Other conditions: Pancreatitis -	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee L. Lavery M.D. M. D. or other
Address: Fruitland Md. Date signed: 7-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 06435 336

Reg. Diat. No. 11

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, institution, or street address where death occurred:
24 State Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 24 State Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter Alfred Venables

3.(b) Social Security Number: "?"

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Venables
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1889

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Delmar, Maryland (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: R.D.Grier & Son

FATHER
12. Name: James R.Venables
13. Birthplace: Portsville, Delaware

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Concord, Delaware

16. Informant: Mrs Mabel Venables
Address: Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-22-47 (month) (day) (year)
Cemetery or crematory: Mt. Olive Methodist
Location: Delmar, Delaware

18. Funeral director: W. S. Mandl Co
Address: Delmar, Delaware

19. July 22, 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I alleoded deceased from July 19 1947, to July 19 1947 and that I last saw h. l m. alive on July 19 1947

Immediate cause of death	DURATION
Hemorrhage	15 minutes
Due to: Hypertension Cardio Vascular Disease	4 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other
Address: Delmar Del. Date signed: July 21 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Sohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06436

932 (D)

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Sussex
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Waller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Waller Mr. John
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1869

8. AGE: Years: 77 | Months: 7 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jacob Messick
13. Birthplace: Delaware

MOTHER
14. Maiden name: Sarah Cooper
15. Birthplace: Delaware

16. Informant: John Keen
Address: Laurel, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29-47 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cemetery
Location: Laurel, Del.

18. Funeral director: Fennell & Tindal
Address: Laurel, Del.

19. 7/28 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947 at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to July 26 1947 and that I last saw her alive on July 25 1947

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. V. Sohler, M.D. M. D. or other
Address: East Street Delmar Date signed: 7-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06437

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1109 North Division Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: B. FRANK WALLER JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Lyda E. Waller 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1879.

8. AGE: Years 67 | Months 10 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Wicomico Co., Maryland (Town, county, and state)

10. Usual occupation: Road Contractor

11. Industry or business: Highway

FATHER
12. Name: B. Frank Waller Sr.
13. Birthplace: Sussex Co. Delaware

MOTHER
14. Maiden name: Fannie E. Wingate
15. Birthplace: Wicomico Co., Maryland

16. Informant: Mr. William Franklin Cooper
Address: Box 51, Snow Hill, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/47 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Maryland

19. 7/19/47 (Date rec'd by registrar) Raquel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 19 47 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 47 to July 17 19 47 and that I last saw him alive on July 17 19 47

Immediate cause of death: Cerebral hemorrhage — DURATION: 6 days
Due to: Mitral insufficiency — 2
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. Farmer M. D. M. D. or other
Address: Salisbury Date signed: July 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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06438

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Del County: Sussex

City or town: Laurel Del R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Waller Mr. Vernon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	S

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 28 1858

8. AGE: Years 58 | Months 11 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace: Near Laurel Del (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Perry O. Waller

13. Birthplace: Del

MOTHER — 14. Maiden name: Elnora J. Robinson

15. Birthplace: Md

16. Informant: Mary Elliott

Address: Sharptown

17. Burial (Burial, cremation, or removal? Which?) Date thereof 7 3 1947 (month) (day) (year)

Cemetery or crematory: Parsonage

Location: Sharptown

18. Funeral director: Graveltor Bros

Address: Sharptown

19. 7/2 1947 (Date rec'd by registrar) Cassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1st 1947 at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/26 1947 to 7/1 1947 and that I last saw him alive on 7/1 1947

Immediate cause of death — DURATION

(a) Bronchopneumonia

Due to: Bilateral

(b) Edema of brain

Due to:

(c) Insanitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles M. Mayo M. D. or other

Address: Laurel, Del Date signed 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M